

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005107	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - CROWN POIN1		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 S MAIN ST CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00176749</p> <p>Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 3/3/16</p> <p>Facility Number: 005107</p> <p>Franciscan St. Anthony Health-Crown Point is in compliance with 410 IAC 15-1.5-10, Utilization review & Discharge planning, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 04/04/16</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE